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ABSTRACT

Many studies have followed the living and work situations of discharged mental patients in the community. To add to this knowledge base, a study of 52 chronic inpatients was conducted over a 3 1/2 year period to examine the effects of deinstitutionalization on the living situations and vocational status of long-hospitalized patients. The patients averaged 39 years of age and 16 years of hospitalization. They were evaluated for living independence at six points in time, and for vocation status at five points in time, from February 1979 to September 1982. Analysis of results showed no significant trends for vocational status. However, results of a repeated measures trend analysis for locational status suggested a significant linear trend. Hence, when chronic patients were discharged into the community, no significant improvement in their work functioning was apparent, nor was there any noticeable pattern of change. But, subjects did tend to move to increasingly independent living situations, though setbacks were noted after a number of years. These setbacks could be accounted for by community resistance and funding shifts. As long as an orderly move to increasingly independent living situations was planned for and was possible, a number of subjects were able to respond to the demand of higher levels of independence. The findings suggest that the degree of living independence and the level of vocational status attained during deinstitutionalization may be related to a multitude of factors both external and internal to the client; the relative contribution of each is a matter for further investigation. (Author/JAC)

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CHRONIC MENTAL PATIENTS AFTER DEINSTITUTIONALIZATION: TRENDS IN LIVING INDEPENDENCE AND VOCATIONAL STATUS

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ABSTRACT

This study examined the effects of a deinstitutionalization policy on the living and vocational status of long-hospitalized psychiatric patients over a 3½-year period. Fifty-two chronic inpatients averaging 39 years of age, and 16 years of hospitalization, all of whom were scheduled for "deinstitutionalization" were evaluated for living independence at six points in time, and vocational status at five points in time from February, 1979 to September, 1982. Instruments were designed by the authors. Results of a repeated measure trend analysis for vocational status indicated no significant trends. However, results of a repeated measures trend analysis for locational status suggested a significant linear trend ($F=11.63$; df, 1, 50; $P<.001$). Hence, when chronic patients were discharged into the community, no significant improvement in their work functioning was apparent, nor was there any noticeable pattern of change. But, subjects did tend to move to increasingly independent living situations, though setbacks were noted after a number of years. These setbacks could be accounted for by community resistance and funding shifts. As long as an orderly move to increasingly independent living situations was planned for and was possible, a number of subjects were able to respond to the demand of higher levels of independence.

Chronic Mental Patients After Deinstitutionalization:

Trends in Living Independence and Vocational Status

This study examines the effects of a deinstitutionalization policy on the living and vocational status of chronic, long-hospitalized patients. The purpose of this investigation was not to assess the effect of specific programs on patients but to prospectively examine the impact of deinstitutionalization as the policy was actually carried out over a 3½-year period on patients in two wards of a state mental hospital.

Many studies have followed the living and work situations of discharged patients in the community. In their exhaustive review and synthesis of the literature, Anthony, Cohen, and Vitalo (1978) found that discharged untreated mental patients have readmission rates of up to 40 percent at six months, 50 percent at one year, and 75 percent at three to five years after discharge. They also found that 30-50 percent of patients were in full-time employment at six months, 20-30 percent were employed at a twelve-month follow-up, and 25 percent were employed at a three-to-five-year follow-up. Most of the studies reviewed by Anthony and his associates were carried out on samples of patients less severely disabled than those currently being deinstitutionalized, which may limit the generalizability of their conclusions. To date, studies involving this population and the long-term effects of deinstitutionalization are incomplete (Bachrach, 1976; Braun, Kochansky, Shapiro, Greenberg, Gudeman, Johnson, & Shore, 1981; Dickey, Gudeman, Hellman, Donatelle, & Grinspoon, 1982).

Of the studies that have been carried out with severely disabled chronic patients, a number of descriptive studies are suggestive. Dickey and her associates (1982) found that more than one-third of their sample of chronic patients had been almost continually rehospitalized since discharge and that

only one-third had been rehospitalized 9 percent or less of the time since discharge. The remaining patients had been hospitalized for a length of time somewhere between the two extremes. Most of the former patients were fairly inactive in their daily activities and interactions. Presly, Grubb, and Semple (1982) found that 43 percent of long-stay patients admitted to a rehabilitation unit made no progress toward discharge to different types of alternative accomodation outside the hospital. Spivak, Siegel, Sklaver, Deuschle, and Garrett (1982) found that only 13 percent of their sample of discharged, long-term patients were working more than half time.

The present study is intended to add to the post-deinstitutionalization literature by providing information about the vocational status and living situations of severely impaired psychiatric patients at different times over a 3½-year period. It analyzes trends in changes of living and vocational status over time for chronic mental patients who have been designated for deinstitutionalization.

METHOD

Subjects

Fifty-four psychiatric patients were followed over a period of 3½ years beginning in February 1979 and ending in September 1982. All patients were initially residents of two wards (each administered by a different area) in Massachusetts. Prior to the study the hospital and state Department of Mental Health articulated a policy of deinstitutionalization and an intention to move most or all of these 54 patients into community settings. The department intended to move the patients through increasingly independent living environments with the hope that some would eventually live in complete independence. An attempt was made, therefore, to establish a range of living environments (halfway houses, supervised apartments, and so on) as well as a range of

vocationally oriented day programming (prevocational workshops, work activity on hospital grounds, and so on). Living environments and day programming varied depending on the geographic area that was responsible for the individual's treatment, but there was sufficient similarity across the two administrative areas to make comparisons. All patients received psychiatric monitoring (monitoring for psychiatric status and medication) during the course of the follow-up, either at the state hospital or, if discharged, through community mental health centers. At the beginning of the study all 54 subjects were hospital residents; 43 subjects were initially on locked inpatient wards, and 11 were residents of a hospital-based quarterway house designed to prepare them for community living. At the beginning of the follow-up period, 18 subjects were not receiving any vocational, prevocational, or daytime programming. Eight subjects were in day activity and another 27 were involved in a prevocational group (discussion group) or a workshop program.

Of the 54 subjects in the original sample, two have died, and the remainder have all been successfully followed up. Their status and progress were corroborated by hospital personnel, community treatment personnel, or significant others.

The demographics of this group of patients reveal the severity of their disabilities, summarized in Table 1. The majority of patients were diagnosed as schizophrenic, schizophrenic and mentally retarded, or organic brain syndrome.

Instruments

With the consent of the two areas and the state hospital, each of the 54 patients was tracked over a 3½-year period, with their vocational status and living status assessed at five points and six points in time, respectively. Despite the fact that there were some differences in the services provided to the subjects in each area, generic measures of vocational and living status were possible.

1. Vocational Status Index. The Vocational Status Index (Farkas, 1980) was developed to measure the degree of vocational or prevocational structure or independence in which the patient is functioning. The degree of independence was defined as the amount of supervision necessary for the performance of work adjustment skills, adjustment training, or job tasks. The scale ranges from day activity (lowest score) to competitive employment (highest score) (Table 2).

2. Location Status Index. Living independence was measured by the Location Status Index (Farkas, 1980), an eight-point scale designed to measure the living independence of psychiatric patients. The scale ranges from the lowest presumed level of living independence (a locked ward) to the highest presumed level (living in the community independently, alone or with a spouse/ roommate). The full scale appears in Table 2.

Results

1. Vocational Status. A repeated measures trend analysis was performed to determine if there was a significant linear or quadratic trend over time (see Table 3). Results of the trend analysis suggest no significant linear trend ($F = 2.80$; df, 45; $P > .05$) and no significant quadratic trend ($F = 2.79$; df, 45; $P > .05$). Despite the lack of a statistically significant trend, an examination of the descriptive measures of vocational activity, in Table 4, suggests that changes in vocational activity over the follow-up period did occur. At the beginning of the follow-up period 18 subjects received no day activity services or programming. By the third follow-up, only five subjects were not receiving any programming, and a large increase occurred in the number of patients in day activity (8 versus 22). By the last follow-up, 22 subjects were in prevocational workshops or hospital-based industry, while only 6 patients were in day activity. There was, however, an increase in the number of subjects who received "no programming." Similarly, the number of subjects in the higher levels of vocational activity (personal adjustment training, extended employment)

decreased from times 1 and 2 to the final follow-up period. Only one subject entered transitional employment, and no subjects entered competitive employment (either full or part time) over the entire follow-up period.

2. Location Status Index. A repeated measures trend analysis was performed to determine if there was a significant linear or quadratic trend in living independence over the course of the follow-up period (Table 5). Results of the analysis suggest a significant linear trend ($F = 11.63$; df, 1, 50; $P < .001$), indicating that patients tended to move to more independent living environments during the follow-up period. These results are apparent in Table 5, which shows a decrease in the number of subjects on locked wards from 43 to 22 during the first three observation periods. Results of the analysis also showed a significant quadratic trend ($F = 14.37$; df, 1, 50; $P < .001$). These trends suggest that after an initial improvement in living independence, patients tended to return to the institution and to less-independent living environments. This finding is confirmed by a descriptive presentation of the data (Table 6), which shows that fewer subjects were in the community at the last follow-up (15 at the last follow-up versus the peak number of 21 at time 5) and that there was a corresponding increase in the number of subjects in the hospital.

Vocational Status

These data suggest that when chronic mental patients were discharged into the community (or were being prepared for discharge) no significant improvement in their work functioning was apparent, nor was there any noticeable pattern of change.

Literature suggests that the vocational status of the severely psychiatrically disabled appears to be related to a variety of factors, both internal and external to the patient. Internal factors that have been suggested include past vocational behavior (Anthony, 1982); patients' inability to choose vocational activities that match their interests and abilities (Loeb, Kaufman,

Silk-Gibran, & Gioe, 1974), and career maturity (Cardiello & Bingham, 1982). External factors that have been suggested include trends in the general economy (Morgan & Cheadle, 1975), governmental disincentives (Lamb, 1981), and limitations on state vocational rehabilitation services to this population (Goshgarian, 1982).

The lack of statistically significant changes in vocational status for the severely disabled patients in this study may be accounted for by fluctuations in both internal and external factors. Movement occurred from higher to lower levels of vocational status apparently as a function of internal factors. For example, two patients returned to the hospital for brief periods between assessments because of an inability to maintain the high level of demand required in the community. Their vocational status decreased commensurately. In addition, anecdotal information suggests that a concentrated period of turmoil in which the community system underwent closings of several houses, funding problems, and high staff turnover was followed by an increase in patient acting-out behavior. Half of the community programs reported that they suspended day programming and work activity for a period of time to allow the residents to stabilize.

On the other hand, some of the increases in vocational status for subjects who had no day programming or day activity during the initial assessment period appear to be related to external factors--an increase in the number of resources available to them. Additional day activity programming was developed in the hospital to prepare patients for deinstitutionalization. Similarly, a prevocational workshop on the hospital grounds was opened between the time of the study's second and third assessments. Consequently, more patients were given the opportunity for prevocational training than had been previously accommodated.

The fluctuations between higher and lower levels appear to be a function of fairly independent internal and external factors. Consequently, while

changes were noted, none were large enough or consistent enough to result in a statistically significant difference.

Location Status

Location status data suggest that when chronic mental patients were discharged into the community (or were being prepared for discharge) they moved to increasingly independent living situations. Setbacks in living independence were noted, however, after a number of years.

The degree of living independence achieved by a psychiatric patient can, in general, be attributed to the same two classes of variables as the degree of vocational status: internal and external factors. The internal factors include such variables as control of psychiatric symptoms and performance of critical community skills (Presly et al., 1982). Factors external to the client include functions that various residential settings play in society (Bachrach, 1976); social stigmas and attitudes that create barriers to building community residences (Seligman, Spanhel, & Lorenzen, 1979); and lack of financial assistance (Lamb, 1981).

Subjects in the present study were strongly influenced by external factors. The increase in living independence, that is, movement toward community living and less structured residential facilities, may be explained largely by an increase in resources and planning. The hospital had as its stated policy the goal of closing "chronic wards" and deinstitutionalizing as many patients as possible. Ward programming was developed to prepare patients. Community residences were bought or rented. After approximately one year, the first group of patients was able to move into their new homes. Community resistance to residences for psychiatric patients delayed the progress of deinstitutionalization for the still-hospitalized individuals. During approximately the last 2½ years of the study significant changes in both the hospital and the community residential system occurred. Patients were reassigned as community residences

were closed because of funding cuts or were limited in the number of patients they could accept. Anecdotal evidence suggests that a combination of the lack of appropriate residential facilities and the turmoil created by the deinstitutionalization effort may have triggered bouts of regressive behavior in a number of residents. This resulted in the return of six patients to the hospital in the latter part of the study.

The hospital attempted to consolidate its functioning, which produced considerable turmoil for inpatients. Several patients who were being "transitioned" out of the hospital via a quarterway house were placed back on locked wards, either because of the lack of community placements or because of their increased agitation during the turmoil. So hospitalized patients, as well as community residents, experienced an eventual decline in their living independence.

Conclusions

Some tentative conclusions may be drawn from this deinstitutionalization effort. It appears that as long as an orderly move to increased independent living situations was planned for and was possible, a number of subjects were able to respond to the demands of higher levels of independence. During this study, once the planned-for movement became stymied by community resistance, funding shifts, lack of general resources, and staff turnover, the progress that the clients had made began to disintegrate. It is also plausible that individual clients respond differentially to the higher demands of community living even with a concentrated amount of staff support and preparation.

It is clear that assessing the continuing impact of deinstitutionalization is a complex matter. The degree of living independence and the level of vocational status attained during the course of the deinstitutionalization process may be related to a multitude of factors both internal and external to the client. The relative contribution of each to the final outcome is a matter of further

investigation. The effectiveness of public policy regarding deinstitutionalization needs to be examined further to avoid simply discarding deinstitutionalization as an ineffective policy for the severely psychiatrically disabled.

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Table 1

Prerelease Demographics of Sample Subjects

Length of Hospitalization	
Prerelease ($\bar{X}$)	16.0 years (range 22 mos. - 449 mos.)
Age ($\bar{X}$)	39.43 (range 22 - 64)
Sex	50% males 50% females

Diagnoses	Number
1) Schizophrenia	33
2) Schizophrenia and mental retardation	13
3) Schizophrenia and Organic brain syndrome/ Senile dementia	3
4) Mental retardation	2
5) Organic brain syndrome/ Senile dementia	1
6) More than two diagnoses	1
7) Unrecorded diagnosis	1

Table 2

Vocational and Location Status Indexes

Activity	Index Score
No activity/programming	1.0
Day activity	2.0
Prevocational group or hospital industry	3.0
Prevocational workshop	4.0
Work adjustment training (in workshop)	5.0
Extended employment (in workshop)	6.0
Transitional employment	7.0
Competitive employment	8.0

Location	Index Score
Locked ward	1.0
Unlocked ward	1.5
Nursing home	2.0
Quarterway house (hospital-based)	2.5
Community group home	3.0
Supervised or cooperative apartment	3.5
Foster home or nuclear family	4.0
Living alone or with roommate/spouse	4.5

Table 3

Trend Analysis of Vocational Activity

Source	df	Sum of sq.	Mean sq.	F
Trials	4.	10.7131	2.6788	1.91
Linear	1.	6.7041	6.7041	2.80^{ns}
Quad	1.	3.6625	3.6625	2.79^{ns}
Res	2.	.3465	.1732	.18
Subjects	45.	271.0305	6.0229	4.28
Error	180.	253.6870	1.4094	
Linear	45.	107.0079	2.3980	
Quad	45.	59.0052	1.3132	
Res	90.	86.6839	.9632	

ns = nonsignificant

Table 4

Changes in Vocational Activity Over Time:

Frequency of Patients in Each Type of Vocational

Status at Different Observation Periods

	Number of Patients				
Vocational Status	Time 1	Time 2	Time 3	Time 4	Time 5
No vocational activity	18	8	5	5	10
Day activity	8	17	22	13	6
Prevocational group	9	8	2	7	3
Prevocational workshop or hospital industry	8	7	13	18	22
Personal adjustment training	10	10	6	2	2
Extended employment	1	4	6	5	3
Transitional employment	0	0	0	1	0
Competitive employment	0	0	0	0	0
	54	54	54	51*	46*

*Two people died during the follow-up study and seven refused to consent to have their vocational status evaluated at time 5.

Table 5

Trend Analysis of Living Independence

Source	df	Sum of sq.	Mean sq.	F
Trials	5.	33.5950	6.7190	12.53
Linear	1.	11.6624	11.6624	11.63*
Quad	1.	10.0383	10.0383	14.37*
Res	3.	11.8943	3.9648	12.14
Subjects	50.	253.6145	5.0723	9.46
Error	250.	134.0718	.5363	
Linear	50.	50.1539	1.0031	
Quad	50.	34.9230	.6985	
Res	150.	48.9949	.3266	

*significant at p .001

Table 6

Degree of Living Independence Over Time:

Frequency of Patients in Each Setting at Different Observation Points

Location	Number of Patients					
	Time 1	Time 2	Time 3	Time 4	Time 5	Time 6
Locked ward	43	42	22	30	24	27
Unlocked ward	0	0	4	0	4	4
Nursing home	0	0	0	2	2	5
Quarterway house	11	7	11	1	0	1
Number of subjects in hospital	54	49	37	33	30	37
Community group home	0	0	7	7	10	6
Supervised or cooperative apartment	0	4	10	11	11	8
Foster care or with family	0	1	0	0	0	0
Alone or with roommate/spouse	0	0	0	0	0	1
Number of subjects in community	0	5	17	18	21	15
Total number of subjects	54	54	54	51	51	52 *

*Two people died during the follow-up period.